Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS – Interface East
2919 Kennedy Street
Palatka, FL 32177
Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for CDS Family and Behavioral Health Services, Inc. – Interface East for the FY 2019-2020 at its program office located at 2919 Kennedy Street, Palatka, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. CDS Family and Behavioral Health Services, Inc. – Interface East is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from CDS Family and Behavioral Health Services, Inc. – Interface East present for the entrance interview were: Tracey Ousley, COO; Cynthia Starling, Regional Coordinator; L'Kescha Mack, Residential Supervisor; and Alex Culbreth, Residential Counselor. The last onsite QI visit was conducted May 23 – 24, 2019.

In general, the Reviewer found that CDS Family and Behavioral Health Services, Inc. – Interface East is in compliance with specific contract requirements. **CDS Family and Behavioral Health Services, Inc. – Interface East received an overall compliance rating of 100% for achieving full compliance with eleven indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, no recommendation was made for an indicator rated as conditionally acceptable.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 03-04-2020

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface East						**Monitor Name: Ashley Davies, Lead Reviewer**	
Contract Type : CINS/FINS						**Region/Office: 2919 Kennedy St., Palatka, FL**	
Service Description: Comprehensive Onsite Compliance Monitoring						**Site Visit Date(s): March 4 - 5, 2020**	
	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members certified as DJJ QI Peer reviewers. One of the staff members has participated as peer reviewer this season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of eight additional contracts for FY2019- 2020. The list includes: the contract #, the agency, contact info, service, start and end dates, date executed, annual amount, any changes to the contract. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	**No recommendation or Corrective Action.**

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Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $20,000 individual medical, $1,000,000 personal & adv injury, and $1,000,000 employee benefits, effective 1/10/20-1/10/21. Automobile insurance through Berkshire Hathaway Specialty Insurance Company, for combined single limits of $1,000,000, and PIP Basic for $10,000. Policy effective for 1/10/2020-1/10/2021. An umbrella liability policy through Berkshire Hathaway Specialty Insurance Company, for $1,000,000 each/aggregate. Workers Compensation through Bridgefield Casualty Insurance Company for $500,000 each accident. Effective 5/1/19 – 5/1/20.	**No recommendation or Corrective Action.**

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						Abuse and Molestation coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/20 – 1/10/21. Professional Liability Coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/20 – 1/10/21. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency had a set of Accounting Policies and Procedures in place for: fiscal management, cash, petty cash, support, program service fees, revenue, and receivables, expenses for program and supporting services and accounts payable, payroll and	**No recommendation or Corrective Action.**

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						related liabilities, governmental financial assistance programs, property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. These polices were last reviewed in October 2019.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY, through 2/3/2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the shelter and each program separately.	**No recommendation or Corrective Action.**
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last onsite program review in May 2019. Reviewed petty cash Policy and Procedure was conducted. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a locked box in the administrative assistants office. All receipts are submitted to the main office for reimbursement as needed. Reimbursement comes in the form of a	**No recommendation or Corrective Action.**

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						check made out to the Administrative Assistant, who will then cash it and place money in petty cash box.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account held with Renasant Bank. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are documented by two signatures. Any corrections or adjustments are documented with reasons why. Invoices are submitted on a monthly basis with supporting documentation.	**No recommendation or Corrective Action.**
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form	☐	☐	☒	☐	☐	Documentation: Agency provided documentation in bank statements that payroll taxes are	**No recommendation or Corrective Action.**

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W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						paid each payroll period to the IRS, for the last six months.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a year-to-date report for the current fiscal year. The report shows Actual, Budget, and Variance with Total Revenues Over Expense. A review of these documents was conducted. Variances in budget are monitored on a regular basis and are discussed with the Board by the Budget and Financial Committee. If changes need to be made to the budget, then the individual shelter is notified.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2019 and 2018 was completed by James Moore & Co., P.L. A report was issued on December 20, 2019. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Back-up, IT Confidentiality Standards, Data Integrity, Record Elimination, Uses and Disclosures of Confidential and Protected Health Information Youth Case Record, and Security. The Medical Manager performs daily back-ups at 2am and prints summary receipt. Back-up tape is replaced every morning. Accounting data files are backed-up every day to USB drive. Other critical servers, microcomputers and laptops complete scheduled back-ups on a secured portable hard drive.	**No recommendation or Corrective Action.**

CONCLUSION

CDS Family and Behavioral Health Services, Inc. – Interface East has met the requirements for the CINS/FINS contract as a result of full compliance with eleven applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no recommendations as a result of this review.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS Family and Behavioral Health Services, Inc. – Interface East Residential Program

March 4 – 5, 2020

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/ Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Overall Rating Summary
Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewer

Members

Ashley Davies - Lead Reviewer Consultant - Forefront LLC/Florida Network of Youth and Family Services

Mike Marino – Regional Monitor - Department of Juvenile Justice

Kristine Harshaw – Regional Monitor – Department of Juvenile Justice

Shirley Moon - Program Manager – Thaise Exposure Tours

Tammy Holcombe – Program Supervisor – Youth and Family Alternatives

Nyesha Logan – Case Manager - NEED

Quality Improvement Review

CDS Family & Behavioral Health Services, Inc. – Interface East – March 4 – 5, 2020
Lead Reviewer: Ashley Davies

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

- ☐ Chief Executive Officer
- ☐ Chief Financial Officer
- ☐ Program Coordinator
- ☒ Direct – Part time
- ☐ Volunteer
- ☒ Clinical Director
- ☒ Counselor Non-Licensed
- ☐ Advocate
- ☐ Nurse – Full time
- ☐ Executive Director
- ☐ Program Director
- ☒ Direct – Care Full time
- ☐ Direct – Care On-Call
- ☐ Intern
- ☐ Counselor Licensed
- ☒ Case Manager
- ☒ Human Resources
- ☒ Nurse – Part time
- ☒ Chief Operating Officer
- ☒ Program Manager
- **1** # Case Managers
- **1** # Program Supervisors
- **NA** # Food Service Personnel
- **1** # Healthcare Staff
- **NA** # Maintenance Personnel
- **NA** # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Logbooks
- ☐ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☒ Fire Inspection Report
- ☐ Exposure Control Plan
- ☒ Table of Organization
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☐ Key Control Log
- ☒ Fire Drill Log
- ☒ Medical and Mental Health Alerts
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☐ Supplemental Contracts
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- **9** # Health Records
- **9** # MH/SA Records
- 3 # Personnel /Volunteer Records
- **8** # Training Records
- **5** # Youth Records (Closed)
- 5 # Youth Records (Open)
- _____ # Other: _____

Surveys

- **3** # Youth
- 5 # Direct Care Staff
- **0** # Other: _____

Observations During Review

- ☐ Intake
- ☒ Program Activities
- ☐ Recreation
- ☐ Searches
- ☒ Security Video Tapes
- ☒ Social Skill Modeling by Staff
- ☐ Medication Administration
- ☒ Census Board
- ☒ Posting of Abuse Hotline
- ☐ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Discharge
- ☐ Treatment Team Meetings
- ☐ Youth Movement and Counts
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☐ Group
- ☐ Meals
- ☒ Signage that all youth welcome

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

The program continues to strive to have a very trauma informed environment and has recently created a new “comfort room”. While planning the contents of the room, they chose numerous calming pictures and surveyed both youth and staff on their choice of the most “calming” picture as well as “calming” colors. They look forward to utilizing the room and seeing positive results for the youth they serve.

Each summer at Interface East, they put forth an enhanced summer shelter program. The 2019 program was themed “MY WHOLE SELF”. It incorporated the concept that in order to be whole and healthy we need to focus not just on our mind or our body but all components that make us whole. Through field trips, guest speakers, and various activities, youth learned how to keep both their minds and bodies healthy. This concept was taught through fostering an appreciation of the arts, music, theater, and visual arts as methods to grow and expand their “self”. The youth enjoyed activities that included a “Paint Party” at a local art studio, trip to the local radio station, a local music center, and they participated in the local library’s summer activities. The youth enjoyed guest speakers that included a local yoga instructor, Putnam Sheriff’s PAL Coaches, and PCSO therapy dog.

The program continues to have challenges in the area of hiring and retention of Youth Care Workers especially for the weekend schedules. They have also experienced some major staff/position losses since the last review. One of their non-residential counselors recently resigned and they are currently advertising for the position. The current Administrative Assistant will be retiring on February 28, 2020, but they are hopeful to fill that position internally. They remain positive about their staffing though because they have numerous staff who have remained with the agency for more than ten years.

As far as the building maintenance and improvements, in October, one of the bathroom showers was remodeled and they had an updated fire suppression system installed in the kitchen during December 2019.

Standard 1: Management Accountability

Overview

CDS Family and Behavioral Health Services, Inc. – Interface East is managed by a Chief Executive Officer and Chief Operating Officer who oversee a Regional Coordinator and Residential Supervisor. The Regional Coordinator and Residential Supervisor are responsible for the day-to-day operations at the shelter. At the time of the review there was one vacant position for a non-residential counselor. In addition, the Administrative Assistance, a long-term employee, will be retiring the week following the on-site review.

The three-year Basic Center Grant they had expired in September 2019 and unfortunately, CDS East was not awarded the grant for another three-year cycle. In that, they lost their Safe Place/Outreach Specialist position and the Life Skills Instructor position.

The program is using the Clearinghouse for background screening. All employees are in the Clearinghouse. The program is using the Criteria assessment as their suitability assessment. Any applicants applying for a direct care position are required to complete this assessment prior to hire.

The program collects and reviews data from various sources on a monthly basis. All data collection is shared and reviewed with management and staff during monthly meetings. Any improvements or corrective actions needed are implemented at this time. The agency also submits a monthly packet to the Board of Directors. The packet includes all outcome data and a review of any incidents that happened at the shelter during that month. The program also provides the Board with a summary of program updates for the month. This packet is reviewed during the monthly Board meeting. Data entry and collection is reviewed monthly during the management team meetings. The Data Department for the agency will print out monthly JJIS and NETMIS reports. These reports are reviewed with all management staff during the meeting to ensure data accuracy.

All indicators in standard one were rated Satisfactory with exceptions noted in 1.03 Incident reporting. The exceptions noted in 1.03 were due to two reportable incidents not reported to the Central Communications Center (CCC) as required. All other indicators in standard one were rated satisfactory with no exceptions.

Standard 2: Intervention and Case Management

Overview

CDS Family & Behavioral Health Services, Inc. – Interface East provides residential and non-residential counseling and case management services over three counties, Bradford, Putnam, and Union, across Circuits 7 and 8.

The Regional Coordinator oversees both programs. The residential counseling program consists of one master's level counselor. The non-residential counseling program is housed on-site. The non-residential program consists of two, bachelor's level, counselor/case managers.

The program has provided Domestic Violence services. The program has not had any examples of Staff Secure, Domestic Minor Sex Trafficking, Probation Respite, or Family and Youth Respite Aftercare Services (FYRAC) youth in the last year. This site also does not provide Intensive Case Management or Stop Now and Plan (SNAP) services. The program is currently maintaining paper files.

All indicators in standard two were rated satisfactory with no exceptions. Indicator 2.10 was rated not applicable because agency does not provide SNAP services at this location.

Standard 3: Shelter Care

Overview

CDS Family & Behavioral Health Services, Inc. – Interface East residential program is led by a Residential Supervisor and a Senior Youth Care Worker who oversees thirteen youth care workers. The shelter runs three shifts. At the time of the review, there were no vacant Youth Care Worker positions.

Other than some minor renovations to a shower, there were no other major upgrades or physical changes to the shelter.

The shelter follows a daily schedule that allows time for school, homework, reading, meals, recreation, and sleeping. The schedule is posted in all common areas throughout the shelter.

The shelter utilizes the FACE System (Facilitating Activity & Communication Effectively) with the intent of increasing youth involvement in the program. Behavioral Expectation forms are reviewed between staff and youth so there is a clear plan designed for each

youth to progress. The FACE System is comprised of three phases: Assessment, Daily, and Achievement. The youth are able to maneuver through the phases, gaining privileges based on their compliance with rules and through demonstrating that they are mastering their targeted skills. Youth are provided with an orientation packet at intake explaining in detail the Behavior Management System (FACE).

CDS Family & Behavioral Health Services, Inc. – Interface East is licensed by the Department of Children and families for twelve beds. The agency serves both CINS/FINS and DCF program participants. At the time of the review the shelter had six CINS/FINS youth.

All indicators in standard three were rated satisfactory with an exception noted in indicator 3.03 Youth Room Assignment. The exception noted in 3.03 was due to no documentation in file to show youth are asked their gender identification at admission. All other indicators in standard three were rated satisfactory with no exceptions.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are overseen by a Regional Coordinator who is a Licensed Mental Health Counselor (LMHC). Services are provided by one, master's level, residential counselor.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form. If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by two part-time Registered Nurses (RN). The RN's split the twenty work hours that are required weekly. The RN will distribute all medications when on-site and trained youth care workers will distribute medications when the RN is not on-site. The RN provides various trainings for staff, including Medication Administration. All staff are CPR and first aid certified.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The RN completes a weekly inventory of all medications on-site. Youth care workers complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications. The shelter does not maintain any over-the-counter medications.

All indicators in standard four were rated satisfactory with exceptions noted in 4.05 Episodic and Emergency Care. The exceptions noted in 4.05 were due to two off-site medical care incidents not being documented on the Episodic Care Log and one the two incidents did not have an incident report completed. All other indicators in standard four were rated satisfactory with no exceptions.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The agency has two policies to address the requirements of this indicator, P-1025 Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns and P-1285 Pre-employment Suitability Assessment. The policies were last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were three staff hired since the last on-site Quality Improvement review. All three staff documented a background screening with an eligible rating was received prior to the staff members hire date. All three staff documented a pre-employment suitability assessment was completed prior to hire using the Criteria assessment. All three staff documented an overall rating of medium or high. All three staff had proof of E-Verify being completed from the Department of Homeland Security.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						There were no staff who required a five-year re-screen during this review period. The agency submitted an Affidavit of Annual Compliance with Level 2 Screening Standards to the Department of Juvenile Justice Background Screening Unit on January 9, 2020.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ **YES** ☐ **NO (explain)** The agency has multiple written policies and procedures in place to address an abuse-free environment that include: P1032 Behavioral Expectations(staff), P1044 Abuse Reporting, P1105 Complaint/Grievance Process, P1128 Rule Violations, and P1212 Standards of Conduct (participants). The policies were last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	No Exceptions
RATING	☒	☐	☐	☐	☐	The procedures for abuse reporting state youth will be provided unimpeded access to report abuse. Staff are obligated to report any suspected abuse. A form to be completed to document abuse reporting is included with the procedure. The procedures for staff behavioral expectations along with the code of ethics in the employee handbook are acknowledged by staff upon hire. The procedures outline actions to be taken if	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						staff violate the code of conduct. Procedures related to participants outline youth and parent/guardian rights, rules, and how rules will be applied in a fairly and equitably. The grievance procedure outlines how participants may grieve and actions to be taken to address grievances fairly and expeditiously. Program rules and standards of conduct are reviewed with youth during the orientation process and acknowledged by the youth signature. Grievance forms are available to youth in the dayroom. There is a lockbox for youth to submit grievances. Only one grievance was filed by a youth during the review period that involved other youths and this grievance was resolved. The number for the Florida Abuse Hotline is posted in common areas and reviewed upon the youth's admission into the shelter. A review of unusual event reports found there have not been any allegations of abuse made against staff. All staff have received training on child abuse reporting.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain)	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency has two written policies in place to address incident reporting titled P-1045 Incident Reporting Procedures and P-1051 Unusual Event Report-Internal. The policies were last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	
RATING	☐	☒	☐	☐	☐	The procedures detail the completion of forms to document events and incidents and the review of incidents. For DJJ incidents, the procedures reflect reporting incidents to the Department's Central Communication Center (CCC) within two hours of the program becoming aware of the incident. The phone number for the CCC and the types of incidents to be reported are included in the procedure. All unusual events and incidents are faxed to CDS administration for review. The program had twelve incidents reported to the Central Communications Center (CCC) during the past six months. All incidents were reported to the CCC within two hours of the program upon staff becoming aware of the incident, except for two incidents that occurred on 11/20/2019 and 1/31/2020. Internal reports were documented for each CCC incident, which were faxed to the corporate office for review, except for the two mentioned reports. Management staff for CDS review all incidents monthly in order to address	Exception: There were two incidents, one on November 20, 2019 and one on January 31, 2020, where a youth was taken off-site for medical care. These two incidents were not reported to the CCC as required. The staff member involved in both incidents no longer works for the agency. The incidents were reported to the CCC during the on-site review.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						any actions needing to be taken. Logbooks reviewed found the reporting of all CCC incidents were noted in "Shift Leader Summary" section.	
1.04: Training Requirements Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1030 Training Policy to address the requirements of this indicator. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were three staff training files reviewed for first year training requirements. The first staff documented 129.5 hours of training This staff documented all required trainings were completed. The second staff documented 87.5 hours of training with approximately one month left to receive additional training hours. This staff documented all required trainings with the exception of Fire Safety Equipment; however, this staff still has time remaining to receive this training. The third staff documented 83 hours of training with approximately seven months left to receive additional trainings. This staff had documented most of the required trainings with the exception of DJJ Skill Pro – Human Trafficking, Fire Safety Equipment, Serving LGBTQ, and Cultural Humility. This staff still had seven	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						months to receive these required trainings. There were five staff training files reviewed for in-service training requirements. All five staff documented over the required 40 hours of annual training. All five staff documented all required trainings were completed. An individual training file is maintained for each staff, which includes an annual training hours tracking form and all related documentation, such as certificates, sign-in sheets, and agendas. The program has an annual training plan in place for July 1, 2019 – June 30, 2020.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1049 Risk Management Plan, Data Integrity, and Data Collection that addresses the requirements of this indicator. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A Performance and Risk Management report are developed every fiscal year. The data is captured using graphs, charts,	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						spreadsheets, and in written forms. This information is also captured and analyzed monthly. Monthly data is collected for participant performance based on contracted deliverables, incidents, accidents, and grievances. The annual CDS Performance and Risk Management report from the past fiscal year was reviewed. The report included performance analysis data from participant satisfaction surveys, demographics of all participants, performance and projections, monthly shelter utilization, outreach, risk, and issue distribution. Other areas addressed include annual data collection of screenings, admissions, discharges, emergency shelter participants, NetMIS data entry, medical emergencies, incident summary report, and personnel summaries. The program conducts quarterly case record reviews. Each counselor reviews eight records. The first two quarters of the fiscal year were reviewed. Each counselor reviewed eight records for a total of twenty-four records reviewed for both residential and non-residential programs. There were no major inconsistencies found in these reviews, requiring any kind of corrective action to be implemented.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						All data collection is shared and reviewed with management and staff monthly as documented in meeting minutes and agendas reviewed. Any improvements or corrective actions needed are implemented at this time. The agency also submits a monthly packet to the Board of Directors for each program operated by the agency. The packet includes all outcome data and a review of any incident that happened at the shelter during that month. Each program also provides the Board with a summary of program updates for the month. This packet is reviewed during the Board meetings as evidenced by meeting minutes. Data entry and collection is reviewed monthly during the management team meetings. The Data Department for the agency will print out monthly JJIS and NetMIS reports. These reports are reviewed with all management staff during the meeting to ensure data accuracy. Any changes that need to be made are made at that time.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) The agency has a written policy in place that addresses the requirements of this indicator titled P-103 Client	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Transportation. The policy was last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	The policy is to provide guidance and best practice model to serve as a protective measure to avoid situations that may place youth and/or staff in danger of real or perceived harm or allegations of inappropriate conduct by either staff or youth. In the event of Residential and Domestic Violence related transports, documentation that notes the name of the driver/second adult, date and time, mileage, number of passengers, purpose of trip will be documented and maintained. Additionally, if a 3rd party is necessary for transport, the policy states that the individual will be an approved volunteer, intern, agency staff, or another youth. In events where a 3rd party cannot be obtained, the agency has a system in place which requires appropriate approval from management staff where consideration is given regarding the client's history, evaluation, and recent behavior. The policy outlines the parameters for which vehicles are to be used, which is for conducting official CDS business unless otherwise authorized by the Chief Executive Officer or his/her designee.	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Only authorized employees may use CDS vehicles and/or drive participants in personal vehicles. Authorized drivers must be approved administratively and on the approved drivers list. Drivers must have and maintain a valid Florida Driver's License and valid Automobile Insurance. The policy states in cases of misuse or abuse CDS assumes no liability and holds the driver accountable for costs or damages that are incurred. In case of accident the agency holds the employee responsible for the proper notifications which include their immediate supervisor and may be held responsible for repairs/deductibles which is at the discretion of the Chief Executive Officer. Prior to CDS vehicle usage and providing transportation to participants, drivers receive driver training in an effort to achieve the safest environment for all involved parties. Each authorized driver is expected to participate in a driver in-service training program to become familiar with the vehicle use and safety inspection policy, their responsibilities, and the vehicles designated to their program. The CDS Procedure also addresses other transportation and safety guidance which includes:	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Driver Training, Driver Selection, During the Use of CDS vehicles, Accident Procedures, Immediately following the Use of CDS vehicles, and Vehicle Safety Inspections. Keys and Proof of Insurance is kept on file and in a secure area. Vehicles insurance and safety inspections were on file and reviewed. Vehicle Annual Safety Inspections for the 2003 Ford Van were dated 1/07/2020 and were satisfactory. Safety Inspection for the 2016 Ford Van were dated 11/26/2019 and were also satisfactory. Vehicle Insurance is up to the date for both vehicles and documentation was on file. The Transportation Logbook along with the Travel Log was reviewed for the last six months. The log documents the date of travel, destination and purpose of trip, trip details (i.e. start/end time) driver, second adult, and approvals information. These logs were consistently filled out in their entirety for the last six months. The Transportation Logbook was cross referenced with the Travel Log for single client transports. A sample of these transports were reviewed from the last six months and all documented the youth was approved for the transport prior to it taking place.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has two policies to address the requirements of the indicator, P-1050 Outreach Plan for Targeting Youth for Program Services, and P-1053 Roles and Responsibilities – Prevention Outreach. The policies were last reviewed by the Chief Operating Officer on January 23, 2020.	No exceptions
RATING	☒	☐	☐	☐	☐	Documentation of outreach services for the past six months was reviewed. The documentation included several cooperative service agreements, meeting agendas and minutes, and information sharing with other community service agencies. The cooperative service agreements included multiple law enforcement agencies, schools, local health and behavioral health providers, other prevention service providers, and family service agencies. The program was represented at DJJ Circuit 7 Advisory Board and Putnam County Juvenile Justice Council meetings. The program was also represented at multiple meetings for the Putnam County	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Behavioral Health Consortium, the Safety Net Alliance, and Project Praise. There was documentation of several other meetings in the community and tours provided at the shelter, which included the Palatka Police Department, Putnam County Sheriff's Office, a local health advisory committee, Department of Juvenile Justice units and staff in Putman and Bradford Counties, multiple high schools and middle schools as well as the school districts served by the shelter, and other similar agencies. Documentation of each meeting indicated who was in attendance and the information shared, to include the number of brochures and business cards handed out. Services available and activities are advertised on the CDS website and Facebook. Pamphlets detailing CDS services and services from other providers are available to visitors at the shelter entrance.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has a written policy in place that addresses the requirements of this indicator titled P-1112 Screening Process. The policy was last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	No Exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed. Of the ten files, five were non-residential and five were residential. Out of the five non-residential, three were open and two were closed. Out of the five residential, three were closed and two were open. All ten files met the Eligibility Screening within seven calendar days of the referral. It was noted that in all ten files, all youth and parents received, in writing, documentation about service options, the rights and responsibilities of youth and parents/guardians, and a parent/guardian Brochure. All ten files reviewed provided written documentation for youth and parents/guardians regarding information on possible actions	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						occurring with CINS/FINS services and Grievance procedures.	
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a written policy in place that addresses the requirements of this indicator titled P-1019 Needs Assessment. The policy was last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed. Of the ten files, five were non-residential and five were residential. Out of the five non-residential, three were open and two were closed. Out of the five residential, three were closed and two were open. All five of the residential files meet the requirement of a Needs Assessment being initiated within 72 hours of admission. All five of the non-residential files meet the requirement of a Needs Assessment done within two or three face-to-face contacts. All Needs Assessments in the ten files reviewed were conducted by a bachelor's or master's level staff member and included a supervisor's signature upon completion. Two out of the ten files reviewed were identified with an elevated risk for suicide and both were referred for an Assessment of Suicide Risk	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						conducted by a licensed mental health professional.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a written policy in place that addresses the requirements of this indicator titled P-1162 Individual Plan. The policy was last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed. Of the ten files, five were non-residential and five were residential. Out of the five non-residential, three were open and two were closed. Out of the five residential, three were closed and two were open. All ten files reviewed met the requirements of a Case/Service Plan developed within seven days of the Needs Assessment. All ten files reviewed documented a Case/Service Plan that included that following: individualized and prioritized needs/goals based on the Needs Assessment, service type and frequency, person responsible, target dates for completion, actual completion dates, signature of youth and parents/guardian, signature of counselor, signature of supervisor, and the date the plan was initiated.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Six out of the ten files reviewed documented the Case/Service Plan was reviewed for progress/revised by counselor/parent, every thirty days for the first three months and every six months after. The four remaining files either were closed before the thirty day mark or were recently opened and it has not been open for thirty days yet.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a written policy in place that addresses the requirements of this indicator titled P-1163 Case Management, Counseling, and Service Delivery. The policy was last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed. Of the ten files, five were non-residential and five were residential. Out of the five non-residential, three were open and two were closed. Out of the five residential, three were closed and two were open. All ten files reviewed were assigned a Counselor/Case Manager. All ten files established referral needs to service based upon the ongoing assessment of youth/family needs, coordinated service plan implementation, monitors youth/family's progress in services, provided support for families, and were referred for additional services when appropriate.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						None of the five non-residential files were necessary to monitor out-of-home placement. None of the ten files reviewed were applicable for a referral to the case staffing to address problems and needs of family, accompanying youth and parent/guardian to court hearings or related appointments, or providing case monitoring and court order reviews Five of the ten files reviewed provided case termination notes and provided follow-up after thirty and sixty days of exit. The other five cases were not applicable due to being open cases.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a written policy in place that addresses the requirements of this indicator titled P-1163 Case Management, Counseling, and Service Delivery. The policy was last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed. Of the ten files, five were non-residential and five were residential. Out of the five non-residential, three were open and two were closed. Out of the five residential, three were closed and two were open. All the files reviewed reflected the youth's case coordination based on the Needs Assessment, Initial Case/Service Plan, case management	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						and follow-ups, case notes maintained for all counseling services, and documented the youth's progress. There was an on-going internal process that ensured clinical review of case records and staff performance. Youth and families are receiving counseling services in accordance with the Case/Service Plan, and the program was providing individual/family counseling. The five residential files that were reviewed were provided with group counseling at least five days a week and there is clear documentation of groups that include a time/date, list of participants, leader/facilitator, relevant topic, opportunity for youth to participate, and length of group session being thirty minutes or longer. The five non-residential files were not applicable.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has three different policies in place to address this indicator, P-1157 Case Staffing Committee: Plan of Services, P-1159 Case Staffing Committee: Review and Committee Composition, and P-1160 Case Staffing Committee: Parent/Guardian Request. The policies were reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	The procedures state that a Case Staffing Committee meeting is to be held to review cases determined in need of services or treatment if: the family or youth is not in agreement with the services or treatment offered, the family or youth will not participate in the services or treatment selected, the counselor/case manager needs assistance in developing an appropriate Individual Plan, the parent or guardian, or any member of the committee requests that a Case Staffing Committee meeting be arranged (If requested by a parent, a Case Staffing Committee meeting must be held within seven days, excluding weekends and holidays, of written request). The counselor/case manager is responsible for implementing and monitoring the Plan of Services. A copy is required to be sent to the parent/guardian within seven days of the meeting to provide a written report outlining reasons for or against a petition being filed and the recommendations. The Case Staffing Committee must include, but not limited to, the following: a representative from the Department of Juvenile Justice or designee in accordance with the CINS/FINS Operations Manual, a representative of the CINS/FINS provider and a representative of the youth's school district. The shelter does not routinely perform case staffing's unless there is a written request by the parent or school. The shelter defers to the school district's truancy petition process	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reportedly under sections 1003.21 and 1003.24, Florida Statutes. The shelter participates in the school district's Student Intervention Team (SIT) and is named as part of the school district's Truancy Procedure. However, referral is made to the program only if there is a determination by the school's "RTI/Child Study Team" that the student "is in need of services at a higher level of care". Documentation was provided for one Student Intervention Team Meeting, which do occur on a monthly basis at the shelter. During this meeting, all truancy cases slated for court the following day are reviewed by the team consisting of: Counselors/Case Managers from CDS East, the Regional Coordinator for CDS East, representatives from the Putnam County School District, representatives from the Putnam County Juvenile Probation Office, and representatives from a partnering agency that provides substance abuse counseling. Further documentation was provided that consisted of notes on the docket paperwork for the youth seen the following day in truancy court. This system demonstrates a high level of involvement by the CINS/FINS program regarding all truancy cases in the county in which the shelter resides.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a written policy in place that addresses the requirements of this indicator	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						titled P-1046 Youth Case Record. The policy was last reviewed on January 23, 2020 and approved by the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed. Of the ten files, five were non-residential and five were residential. Out of the five non-residential, three were open and two were closed. Out of the five residential, three were closed and two were open. All ten files that were reviewed were marked "Confidential". Observed that all records are kept in a secure room and locked in a file cabinet that is marked "Confidential". Observed all records, when transported, are locked in an opaque container marked "Confidential". All records observed were maintained in a neat and orderly manner.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1284 Sexual Orientation, Gender Identity, and Gender Expression that addresses the requirements of this indicator. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter has signage located throughout the shelter including in the hallways, lobby, staff offices, and boys and girl's dayroom indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						expression. The actual SOGIGE policy is hanging up in the staff office for staff to easily see and review. The residential counselor completes different groups with the youth on appreciation for diversity, sexual identity, same sex relationships, and awareness and acceptance. The groups include vocabulary terms, worksheets, and tests. The counselor also completes these same trainings, with the tests and worksheets, for all staff. The counselor also has copies of the Zine available for any youth who want it. Copies of the Zine are also located in the lobby for visitors, volunteers, or staff who may want one. The program has one youth who was a female who identified as a male. This youth was addressed by their preferred name and pronoun. This youth's preferred name and pronoun was used in the logbook, on the census board, and on all outward facing documents. Specialized support was provided to this youth and family. This youth was able to choose were they wanted to sleep and the youth chose to sleep on the female dorm. The youth was able to dress in clothing and use hygiene products that affirmed their gender identity.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has six policies in place that address the requirements of this indicator. The	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						policies are titled P-1249 Staff Secure Shelter – Program Overview, P-1248 Staff Secure Shelter Services, P-1282 Domestic Minor Sex Trafficking, P-1267 Domestic Violence Respite, P-1279 Probation Respite, and P-1283 Family/Youth Respite Aftercare Services (FYRAC) Non-Residential Services. These policies were last reviewed on January 23, 2020 by the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	The program has not had any Staff Secure, Domestic Minor Sex Trafficking, Probation Respite, or FYRAC youth since the last on-site Quality Improvement review. This program also does not provide Intensive Case Management Services. The shelter has had one Domestic Violence (DV) Respite youth in the last six months. This youth had a pending DV charge and was referred by the Juvenile Probation Officer (JPO) due to not meeting criteria for secure detention. All data was entered into JJIS within twenty-four hours of admission and release and into NetMIS within seventy-two hours of admission and release. The youth did not stay in the program longer than twenty-one days. The Case Plan reflected goals focusing on aggression management, family coping skills, and other interventions designed to reduce the reoccurrence of violence in the home. All other services provided to the youth were consistent with all other general CINS/FINS program requirements.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☒ NO (explain) Not applicable	Not applicable
RATING	☐	☐	☐	☐	☒	Not applicable	The agency does not provide SNAP services at this location.

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has three policies in place to address the requirements of the indicator P-1122 Leisure Activities Program (LEAP), P-1137 Faith Based Activities, and P-1210 Shelter Environment. The policies were reviewed on January 23, 2020 by Chief Operating Officer.	No Exceptions
RATING	☒	☐	☐	☐	☐	A tour of the facility was provided by the Residential Supervisor. The facility is well kept and free of any insect infestation, hazards, and debris. The youth have a flower garden which is well kept and appears to be free of insects. The youth are also in the process of planting a vegetable garden. There is a basketball and volleyball court for outside activities. The agency has two vans which upon inspection appear clean and well-kept. The vans were locked and contained all mandatory safety equipment and medical emergency kits in both vans.	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						A copy of the DCF license was found on display in the main lobby and is current. All fire and health inspections were also current. Upon inspection, both the male and female youth rooms and bathrooms were found to be clean with no graffiti or hazards. A review of fire inspection reports indicated that the facility is in compliance with the local fire marshal. In addition, staff complete a minimum of one fire drill per month within two minutes or less and one mock emergency drill for each quarter the last fire drill was completed on 03/04/20 and the last mock emergency drill was completed on 1/20/20. The youth schedule is available throughout the facility. A youth schedule was reviewed which outlined education, recreation, counseling, and social skills activities youth are involved in during their stay. The logbook was reviewed and confirmed the schedule was consistently followed.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain)	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency has a written policy in place for Program Orientation, P-1114, Admission/Intake and Participation Orientation. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	At intake each youth is provided a detailed orientation by a staff member informing the youth of the following: key staff and their roles, program dress code, list of prohibited contraband, grievance procedures, tour/physical layout of the facility, access to medical and mental health procedures, review of program rules, and disciplinary actions. There were five files reviewed, two closed files and three open files. The program provides a detailed orientation to each youth within twenty-four hours of entering the facility. Each file contained documentation indicating that program orientation was completed by staff with each youth within twenty-four hours. The program orientation was signed off by staff, youth, and parent/guardian.	No Exceptions
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1116 Youth Room Assignment that addresses the requirements of this	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						indicator. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	
RATING	☐	☒	☐	☐	☐	During the intake process, each youth is assigned a bed based on the information obtained from the youth, parent/guardian, and outside related sources that may have knowledge of the youth's history. The program takes into consideration several factors when assigning a youth to a bed including suicide risk, physical characteristics, mental or physical disability, gang affiliation, and aggressive/violent behavior. There were five youth files reviewed, two closed files and three open files. All five files confirmed that staff make bed assignments based on the above-mentioned information obtained from the youth, their parent/guardian, and outside sources when appropriate. The facility has dorm style rooms, one for males and one for females, with multiple bunk beds in each. Staff was able to articulate how bed assignments are made and what factors are taken into account to determine if a youth is placed on a top verses bottom bunk. Youth who are placed on sight and sound during sleeping hours sleep in the boys or girl's dayroom to allow for a direct line of sight supervision by a staff member.	Exception: Upon reviewing files, it was noted that there was no indication on any of the paperwork that ask a youth their Gender Identification. Per a conversation with the counselor, the counselor will ask the youth the question and if they identify different than their birth gender, it is noted in the file.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1149 Log Books that addresses the requirements of the indicator. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	No Exceptions
RATING	☒	☐	☐	☐	☐	The shelter currently uses a paper logbook for staff to document daily program activities, events, and any incidents occurring at the shelter during each shift. The staff use color codes for highlighting important information in the logbook which includes general information, reviews, suicide, and medications. When reviewing the logbook, it was evident that the highlight codes were used properly throughout each shift viewed. The logbook consists of key sections filled out by staff including staff on duty, shift leader assignments/review, informal count, and medications issued. Staff documents assignments that have been completed by staff and youth. Staff documents any alerts, counts, and medications for the previous/next shift clearly in the logbook. The shift leader completes the first sections with staff on duty and documents youth count at the beginning of the shift along with the previous dates and shifts reviewed. Staff document review of the past three shifts	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						when coming on duty. At the end of the shift, the shift leader documents a summarization of events from the shift and makes comments as needed. Shift leaders review the logbook daily and provide oversight and instruction in the logbook each shift. The residential supervisor reviews the logbook weekly and documents the review. All entries were clear and legible.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has several policies in place to address Behavior Management Strategies. Policies P-1222, P-1123, P-1125, P-1126, P-1127 and P-1128 were last reviewed on January 23, 2020 by the Chief Operating Officer.	No Exceptions
RATING	☒	☐	☐	☐	☐	Youth are provided an orientation packet at intake explaining in detail the Behavior Management System (FACE). Five residential files were reviewed, and each file contained documentation with the youth's signature indicating they were given this information. All staff are required to have training on the FACE system to learn to effectively use and apply the system. Feedback is provided to staff regarding their use of the FACE system rewards and consequences. Youth are encouraged to	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						make positive decisions and staff do not use punishment as a tool. The Residential Supervisor discusses youth's achievements with the youth and has them explain how they accomplished the achievement. The goal is to have them maintain and progress. Ceremonies are performed for youth in which they are presented with certificates for their achievements. Youth can use points earned to purchase items from the Achievement Store, go on outings, buy extra snacks, get video game time, and other incentives.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has two policies to address Staffing and Youth Supervision. Policies P-1121 Supervision and Staffing Ratio & Scheduling and P-1133 Bedtime Supervision and Bed Checks were last reviewed on January 23, 2020 by the Chief Operating Officer.	No Exceptions
RATING	☒	☐	☐	☐	☐	The procedures designate the Regional Coordinator/Designee as being responsible for scheduling and assuring all coverage requirements are in accordance with Florida Administrative Code and Contract. The residential programs shall maintain the minimum following staffing ratio: one staff	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						to six youth during awake hours and community activities and one staff to twelve youth during the sleep period. Volunteers, practicums, and interns may not be used in calculating ratios. The staff is expected to cooperate in the event of rescheduling due to unforeseen circumstances i.e. absence of other staff members, illness, etc. In reviewing the staff schedules, the program maintains staff ratios as required by the Florida Administrative Code. The program staff schedule is posted in a place visible to all staff. There is a holdover overtime rotation roster that includes contact numbers to reach these staff when additional coverage is needed. The Overnight Bed Check Log was reviewed and documented that all bed checks were completed within the required fifteen-minute time frame for the last six months. There were four days of video surveillance reviewed to verify that bed checks were being completed. The review of the video confirmed the bed checks were being completed as documented for those four days.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain)	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency has a policy in place to address the Video Surveillance System. Policy P-1280 was last reviewed on January 23, 2020 by the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	Cameras are mounted in visible locations and the system has the capability to store video for a minimum of thirty days as required. Cameras have the capability of operating during power outages as a back-up in the event of an unexpected power outage. There is a written notice posted in the interior entrance hallway notifying visitors of surveillance for the purpose of security. All cameras are visible and strategically placed both inside and outside of the facility with facial recognition capability and can capture and retain images. The Program Director and the Program Supervisor are on the Camera Access-Approved Personnel list for both on and off-site permissions. If a request for video recordings are made from program quality improvement visits or when an investigation is pursued after an allegation of an incident, it will be made available within 24-72 hours. The program was able to show a document displaying a backup system for	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the cameras in case of a power outage. The program also has a sign displaying that there are surveillance cameras up for the purpose of safety. The program has sixteen operational cameras. No cameras were placed in bathrooms or youth sleeping quarters. The program conducts a random sample review, by a Supervisor, of video which includes overnight shifts. The agency's procedure meets the fourteen-day minimum requirement and was evidenced through an analysis of program logbooks, and by interviewing staff. There were verified surveillance reviews by a supervisor within the last six months identifying the practice in place if a request for video recordings for QI visits is made or when an investigation is initiated after an allegation of an incident which states the video will be made available within 24-72 hours.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes. Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** The agency has two policies to address the requirements of the indicator, P-1117 Residential Admission: Preliminary Physical Health Screening, and P-1118 Residential Admission: Medical Follow-Up. The policies were last reviewed by the Chief Operating Officer on January 23, 2020.	No exceptions
RATING	☒	☐	☐	☐	☐	Five open and four closed records were reviewed. Initial healthcare screening was completed on all nine youth on the day of admission. The screening addressed all required elements. The nurse completed all nine screenings. Alerts were identified, as applicable. The program has procedures in place for follow-up medical care if it is needed.	No exceptions
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)**	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency has four policies to address the requirements of the indicator, P-1144 Mental Health, Substance Abuse and Suicide Risk Screening (Residential), P1247 Suicide Assessment (Residential), P1262 Suicide Assessment (Non-Residential), and P-1152 Mental Health, Substance Abuse and Suicide Risk Screening (Non-Residential). The polices were last reviewed by the Chief Operating Officer on January 23, 2020.	
RATING	☒	☐	☐	☐	☐	Five open and four closed records were reviewed. Initial suicide screening was completed on all nine youth. Five of the youth were put on suicide precaution due to the results of the assessment. All five youth were placed on sight and sound supervision. All five youth were seen and assessed, by a master's level counselor, within twenty-four hours. All five youth documented a suicide risk assessment was completed by a master's level counselor and documented consultation with the LMHC and Residential Supervisor. Both the LMHC and Residential Supervisor signed the assessments prior to the youth being removed from suicide precautions. The youth were placed on normal supervision. All five youth had thirty minute observations documented the entire time on suicide precautions.	No exceptions
4.03: Medication							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a policy to addresses the requirements of the indicator, P-1120 Medication Provision, Storage, Access, Inventory, and Disposal. The policy was last reviewed by the Chief Operating Officer on January 23, 2020.	No exceptions
RATING	☒	☐	☐	☐	☐	The program stores youth medication in a Pyxis Med-Station Medication Cabinet or a secured refrigerator. The program has designated three super users for the med-station. Staff permitted access to medications are identified in writing, and each staff on the list received training on distributing medication, including use of an Epi-Pen. Temperature logs for the refrigerator showed it is maintained at the required temperature range. The area where the Med-station and refrigerator are located is not accessible to youth unless accompanied by staff. Controlled medications are stored in the Med-Station. There were no youth in the shelter on controlled medications at the time of the review, though records reviewed for youth previously in the shelter showed perpetual and shift-to-shift inventories were documented for controlled medications with two staff initialing each shift inventory. Medication	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						distribution logs for individual youth showed perpetual and weekly inventories for non-controlled prescription medications and over-the-counter medications taken on a regular basis. The program does not maintain any stock medications. Discrepancies in medication counts and medications errors were cleared by the end of the shift and training was documented for staff when errors or discrepancies occurred. A nurse runs/reviews medication management reports from the Pyxis Med-Station.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** The agency has a policy to address the requirements of the indicator, P-1119 Medical and Mental Health Alert. The policy was last reviewed by the Chief Operating Officer on January 23, 2020.	No exceptions
RATING	☒	☐	☐	☐	☐	The program maintains an alert board for all alerts and a separate binder for food and medication allergies. Nine youth records were reviewed. Two youth had alerts, one medical (chronic condition) and one food allergy. The alerts were accurately reflected in the binder and alert board.	No exceptions
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement						☒ **YES** ☐ **NO (explain)**	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
for Indicator 4.05						The agency has a policy to address the requirements of the indicator, P-1166 Episodic Emergency Care. The policy was last reviewed by the chief operating officer on January 23, 2020.	
RATING	☐	☒	☐	☐	☐	Five instances of episodic care were reviewed. Three of the five instances were documented in the episodic care log. In one case, the youth received a minor injury while at the shelter and staff provided first aid care on site. The parent/guardian was notified of the youth's injury and care provided. Four youth were taken off-site for medical care by their parent/guardian. Incident reports were completed in three of four cases. Medical clearance and discharge instructions were included in each record. There are four first aid kits located throughout the shelter. The kits are checked monthly by a youth care worker. A detailed report is completed when the kits are checked documenting an inventory, all expiration dates, and what was replenished. These reports were reviewed for the last six months. The shelter has both a knife for life and wire cutters located in the top drawer of a filing cabinet in the youth care worker office. A review of training files revealed	Exception: The episodic care log did reflect two youth being taken for off-site medical care. An incident report was not completed in one of the two cases.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						all staff have a current CPR and first aid certification.	